DISCUSSION OF GROUP PRACTICE IN THE EDUCATION OF MEDICAL STUDENTS*

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PERHAPS I am naive, or it may be that from my vantage point I am prejudiced and unable to appreciate another viewpoint, but I fail to see any alternative to group practice—and, specifically, I do not see how any medical school could endorse any other type of delivery of health services.

By this statement I do not wish to denigrate the contributions of the solo practitioner of yesteryear—he performed a valuable service and, at times, the highest quality of the most diverse types of medical service available anywhere—but this proficiency in all areas of medicine is no longer possible or required in any area of the United States today. Transportation to specialized health-care facilities of quality is possible within a few hours at most from almost any part of the United States. The fact that this does not occur more often than not is, to me, a problem of logistics, communication, planning, and education rather than a deficiency of health facilities or manpower. And to me, the improvement of the former would be much more economical and efficient than expansion of the latter. The experience of the Armed Forces Burn Center at Houston, which treats patients who have been burned from almost any part of the world, testifies to the effectiveness of a center of excellence when patients can be delivered to it rapidly and by preplanned design.

Group practice, particularly by medical schools, is not new. Indeed it existed at Bellevue and other hospitals before 1900, following an era of *geheimrot* leadership where medical and surgical services were named after the physician in charge: Willard Parker's service, Halstead's service, Welch's service, Jacobi's service, Osler's service, to name a few.

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Such nomenclature gave credit to those leaders who defined, by themselves, top-quality medical care for the widest gamut of illness and accident. As medicine refined its classifications of disease the specialties and subspecialties proliferated until, today, most medical centers will operate 40 to 60 specialty clinics. Similar but less numerous clinics at Bellevue 25 and 40 years ago were indeed group practice clinics which attracted the best men in the profession, and they were multiplied throughout the country in city and county hospitals. The Mayo, Ochsner, and Leahy clinics, consciously or unconsciously, borrowed this idea of group practice which had developed to care for the indigent and applied it very successfully to provide quality care for the wealthy. Similar but less formal groups were soon operating at the Massachusetts General, Columbia, Johns Hopkins, and a host of other institutions which were group practice units in fact, even though each individual physician might have denied his dependence on the group for the quality of care which his patients received.

It is probably an oversimplification, but I suspect that the changing economics of medical care has created many of the problems which stimulate a conference of this kind. Historically physicians always have made a lot of money. Although it may seem rather noble and self-sacrificing that the horse and buggy doctor of 1890 would receive one dollar for a house call, it is not usually realized that the average cash income of the population he was serving at that time was less than $400 a year. With such an enormous economic advantage over the rest of society it is not surprising that the prominent physician of 50 and even 25 years ago could and did afford to spend an enormous amount of his time in the free clinics of Bellevue, Roosevelt, Presbyterian, St. Luke's, and New York hospitals, and in hundreds of similar institutions outside of New York. Soak the rich so that one could treat the poor was a form of health insurance that had a certain effectiveness since it was widely assumed when I was in school, and I think the assumption was correct, that the very rich and the very poor got the best of medical care. Those in between wealth and poverty fell through a very wide crack.

Today insurance programs, union health and welfare funds, Medicare, Medicaid, the Veterans Administration, and a host of welfare programs are picking up the tab for professional services formerly borne at least in part by the physician himself. In addition, the demands for health service have multiplied as the public has become aware of symp-

toms and signs which might be ameliorated or removed by appropriate medical attention. And, finally, responsibilities for ancillary services formerly assumed by the church and other groups, or completely ignored, have been thrust on the profession, creating an impossible load which is being transferred gradually to what is now called paramedical personnel.

Group practice is a partial answer to some of these problems, chiefly because of increased efficiency of operation and the greater potential for the training of ancillary paramedical personnel to assist the physician. In a medical school I would include in the group the entire medical faculty, including those members of the basic science departments and the departments of preventive medicine whose members do not contribute directly to the income of the group, but which do enhance the earning capacity of the clinicians because of their contributions to the reputation of the medical school which then by its reputation attracts the patients. By this I do not mean to imply that the clinicians should be the sole support of these scientists and their research and teaching programs, but they should help, because part of their income is a reflection of the realization by patients of the back-up support rendered indirectly by these men.

It is distressing to me, and to most medical school deans, that we and our faculties have virtually lost control of our destinies. Well-meaning individuals, foundations, or agencies with interests of their own and cash to back them up entice our faculties to embark on programs that seem attractive on the surface and actually may be advantageous to those with special interests but which, in the long run, threaten our primary missions. The National Institutes of Health (NIH) themselves, by pouring huge sums of money into research, have threatened the quality of our teaching programs by providing higher rewards for research and thereby making the teacher a second-class citizen. And now, when research funds are being curtailed, our problems are compounded as we seek to maintain our obligations to those researchers who may not have made or may not be able to make significant teaching or service contributions.

The NIH have recognized the problem they have created, and are taking steps to remedy the imbalances which their policies have generated. I wish that other agencies would similarly recognize the problems which they can generate by insisting upon accountability for only

that part of a medical school or group practice program with which they have particular concern.

Medical schools should be asked to account for total programs. Each program should include a proper balance of health services, research, and teaching. It should serve as a model for other groups in the community and the nation. Particularly, it should serve as a model for the medical student who should learn in this setting, and become aware that although it may not be possible to solve all the health care problems of a community, that at least careful consideration should be given to such problems, and that priorities should be thoughtfully established for the utilization of existing resources so that the effectiveness of total health services is not jeopardized by a lack of balance among its various components.